Oversight Division

Committee On Legislative Research

PROGRAM EVALUATION

Application Process and Eligibility Verification of Medicaid

Program Evaluation
Application Process and Eligibility Verification of Medicaid

Prepared for the Committee on Legislative Research
by the Oversight Division

Mickey Wilson, CPA, Director

Review Team: *Carla Mitan, CPA, Team Leader, Steve Shiery, CPA, Helen Webster-Cox, CPA, Linda Dudgeon, Valerie Lesko, Robert Knodell*

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Members of the General Assembly:

The Joint Committee on Legislative Research adopted a resolution in May 2004, directing the Oversight Division to perform a program evaluation of the application process and eligibility verification of Medicaid to determine and evaluate program performance in accordance with program objectives, responsibilities, and duties as set forth by statute or regulation.

The report includes Oversight's comments on internal controls, compliance with legal requirements, management practices, program performance and related areas. We hope this information is helpful and can be used in a constructive manner for the betterment of the state program to which it relates. You may request a copy of the report from the Oversight Division by calling 751-4143.

Respectfully,

Representative Rod Jetton
Chairman

EXECUTIVE SUMMARY

In our review of Medicaid eligibility, we found that the Department of Social Services, Family Support Division, (FSD) has developed standards for determining eligibility based on federal and state laws and regulations. However, a combination of weak computer systems and staff errors has resulted in a failure to review continued eligibility for many recipients, and has let potentially ineligible recipients remain in active status.

- Files we reviewed did not include evidence that caseworkers had verified applicant information that is essential to a correct determination of eligibility and benefit level.
- We found instances in which applicants assets and income were understated, or in which asset transactions were used to enhance applicants' eligibility or benefits.
- We believe that an integrated application and processing system, using updated computer information systems, would reduce errors and staff time needed to maintain recipient records.
- Annual eligibility reviews were often not completed timely, partly because information in computer information systems is not transferred automatically among programs.
- Applicants who had other insurance overage available were not referred to the benefits coordination section for a determination of the best combination of Medicaid and/or other health care coverage.
- We found several cases in which individuals' benefits were incorrectly computed because annual verifications were not completed.
- We found recipients with addresses from other states but received Missouri Medicaid benefits.
- We found 325 state of Missouri employees, that were enrolled in Missouri Medicaid as well as Missouri sponsored employer health insurance resulting in a duplication of state funds of approximately $1,836,000.

Our recommendations include better coordination between programs operated by the Department of Social Services, Family Support Division, more attention to verification of applicant and recipient data, and updated computer information systems to reduce errors and staff time involved in processing applications and recipient files.

Mickey Wilson, CPA
Director

Chapter One - Introduction

Purpose

The General Assembly has provided by law that the Joint Committee on Legislative Research may have access to and obtain information concerning the needs, organization, functioning, efficiency and financial status of any department of state government or of any institution that is supported in whole or in part by revenues of the State of Missouri. The General Assembly has further provided by law for the organization of an Oversight Division of the Joint Committee on Legislative Research and, upon adoption of a resolution by the General Assembly or by the Joint Committee on Legislative Research, for the Oversight Division to make investigations into legislative and governmental institutions of this state to aid the General Assembly.

The Joint Committee on Legislative Research directed the Oversight Division to perform a program evaluation of the Department of Social Services, Family Support Division, Application Process and Eligibility Verification of Medicaid for the purpose of providing information to the General Assembly regarding proposed legislation and appropriation bills.

Background

The United States Congress authorized the federal Medicaid program as Title XIX of the Social Security Act in 1965 to provide health care services to low income persons who are age 65 or over, blind, have a disability, or members of families receiving aid to dependent children. In October of 1967, the 74th Missouri General Assembly enacted legislation establishing the Missouri Medicaid program. New services covered by the program included outpatient hospital care, physicians' services, and professional nursing home care. When Medicaid began, the program was limited to health care coverage for persons receiving cash assistance.

Since that time, federal legislative mandates and options have expanded eligibility to include categories of individuals not receiving cash assistance such as additional elderly, blind, and disabled individuals, children and pregnant women in poverty, refugees, and children in state care. Title XIX now requires coverage of mandatory eligibility groups and services, and allows states to cover optional groups and services. A major expansion was the authorization of the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. The Missouri Medicaid program is jointly financed by the federal government and the State of Missouri. The Department of Social Services, Division of Medical Services (DMS) administers the Medicaid program including establishment of benefit coverage, rates, and claims processing. Medicaid eligibility rules are the responsibility of the Family Support Division of the Department of Social Services. The goals of the Medicaid program are to promote good health, prevent illness and premature death, correct or limit disability, treat illness, and provide rehabilitation to persons with disabilities.

Program Operations

Some persons receive Medicaid benefits through a "fee for service" arrangement, while others receive benefits through a managed care plan. Persons receiving Medicaid benefits through a fee for service arrangement may choose any vendor enrolled to participate in the Medicaid vendor plan. Medicaid pays providers of services, and does not make direct payments to persons who receive medical services. Persons receiving Medicaid benefits through a managed care plan must obtain all needed services through the health plan organization, physician sponsor, or other designated single source for health care. Medicaid pays the managed care plan a capitation fee for each eligible individual enrolled.

DMS coordinates benefit coverage with insurance carriers and also integrates coverage with Medicare for eligible individuals. If an eligible person has other medical insurance, that insurance company must be billed before Medicaid is billed. DMS pays only the deductibles and coinsurance for services covered by Title XVIII (Medicare) of the Social Security Act. DMS also pays the monthly premium for Medicare supplementary medical insurance for eligible assistance recipients age 65 or older and for certain blind or disabled persons.

Eligibility

The Department of Social Services, Family Support Division (FSD) determines client eligibility for the Medicaid program. Medicaid coverage is limited to individuals who meet the requirements of a specific mandatory or optional eligibility category. With a few exceptions these requirements include having income below a certain limit based on family size. In some cases Medicaid coverage is based on the level of a person's medical need such as requiring nursing facility care in a nursing facility, or Home and Community Based care to prevent institutionalization. Medicaid coverage is automatically provided to recipients of cash assistance programs for Supplemental Nursing Care, Supplemental Aid to the Blind, and Supplemental Payment to 1973 Conversion cases. State funded medical assistance is also provided to Blind Pension Fund recipients, and persons who meet the requirements of the former General Relief program.

The federal Medicaid statutes and regulations identify over 30 mandatory and optional eligibility groups for which federal matching funds are available. Some of the major groups covered in Missouri are:

> Pregnant Women; this program provides healthcare coverage including sixty day postpartum coverage for pregnant women whose family income does not exceed 185% of the federal poverty level for their household size. Once a woman is determined to be eligible, coverage continues through the pregnancy and postpartum period despite subsequent increases in income.

Newborns; this group includes children born to a woman eligible for and receiving Medicaid on the date of the infant's birth. The child will remain eligible for Medicaid coverage through the first year of life so long as the child remains in the mother's home in Missouri.

Children under the age of 19 who have net family income that does not exceed the applicable limit. The income limits are 185% of the federal poverty level (FPL) for children under age 1, 133% of FPL for ages 1 through 5, and 100% of FPL for ages 6 through 18.

Uninsured children under the age of 19 of who have family income above the limits for the preceding group may be eligible for MC+ for Kids, part of the federal State Children's Health Insurance Program (SCHIP). Gross family income must be below 300% of the federal poverty level (FPL). If the family income is above 225% of FPL, the family is eligible only if access to affordable health insurance is not available. Some MC+ for Kids families are required to pay monthly premiums and coinsurance based on family income, but a family's cost is limited to no more than 5% of their annual income.

Parents and children in families with income that does not exceed 75% of the federal poverty level are eligible for the Medical Assistance for Families (MAF) program.

Persons who are elderly, blind, or have a disability, and whose income does not exceed 100% of the federal poverty level are eligible for Medicaid if their available assets are below a specified limit. In addition, if their income is above 100% FPL they can receive coverage only on a spenddown basis. Spenddown coverage is provided for medical expenses above the amount by which income exceeds 100% FPL. For spenddown persons in nursing facilities, the person pays all of their monthly income except for certain allowances to the nursing facility.

The Medical Assistance for Workers with Disabilities (MA-WD) program is a Medicaid program for persons age 16 through 64 who have a disability, are employed, have income that does not exceed 250% of the federal poverty level (FPL), and have available assets below the program limit. Persons with income above 150% FPL must pay a monthly premium.

Additional groups not defined above are also provided services under the Medicaid program. Pregnant women and children can receive services under a Presumptive Eligibility program until their actual eligibility can be determined. Transitional Medical Assistance provides up to 12 months of coverage to persons who become ineligible for Medical Assistance for Families due to earnings, and Extended Transitional Medical Assistance provides an additional 12 months of coverage to uninsured parents who lose coverage under the Transitional Medical Assistance program. Finally, General Relief provides limited state only funded medical coverage to needy, unemployable persons who do not qualify for any federally matched Medicaid program.

Objectives

The primary focus of the evaluation was to provide the General Assembly with information regarding the application process and eligibility verification of Medicaid for consideration in proposing legislation and reviewing appropriation bills. The Oversight Division concentrated on the following primary objectives:

- To determine if eligibility requirements are adequately documented
- To determine if Medicaid reverifications are done on an annual basis
- To determine if DOS is coordinating Medicaid benefits with other available insurance

Scope/Methodology

The scope of the evaluation included the period of July 1, 2003 through June 30, 2004. The methodology used by the Oversight Division included review of FSD records and policies and discussions with FSD personnel.

Chapter 2 - Comments

Comment 1

FSD did not adequately document that recipients met all eligibility requirements.

ELIGIBILITY VERIFICATION AND DOCUMENTATION PROCESS

Each of the Medicaid programs managed by the Department of Social Services, Family Support Division (FSD) has specific eligibility requirements that are included in federal or state legislation or in FSD regulations. FSD caseworkers are responsible for obtaining and recording information in the case record that clearly shows all eligibility requirements for a program have been met. FSD requires anyone who applies for assistance to furnish information necessary for determining eligibility, both initially and on a continuing basis. It is the caseworker's responsibility to inform the applicant what specific information is needed and the applicant is given at least ten days to supply necessary information. It is the applicant's responsibility to provide the caseworker with enough information so an eligibility determination can be made.

An applicant whose income or assets exceed program limits or who declines to provide the information necessary to determine eligibility, is required to be rejected. Oversight noted instances in which ineligible applicants received benefits and instances in which caseworker decisions were not consistent with documentation in applicant files. Oversight also noted that adequate evidence of eligibility was simply not available in a large number of recipient files. Oversight's specific concerns are detailed below.

Dependent Birth Records

FSD requires verification of age and relationship of a child to their parent or caretaker for all applicants/recipients born in Missouri. Oversight noted that the FSD computer system performs verification of children born in Missouri by cross-referencing to Missouri birth records.

We also noted in our review of files that in 23% of recipient families, some recipients were born in other

states. Birth record verification is not applied to anyone born outside Missouri, however. Verification of age and relationship by obtaining birth records of all family members should be considered to ensure that benefits are only provided to eligible persons.

Oversight recommends FSD require birth records for verification of age and relationship of a child to their parent or caretaker in all cases.

Addresses

Oversight found lack of verification of the applicant's actual address. In 55 of 123 (45%) files reviewed, we found no address verification, or a verified address different from the file address. We also noted that four families had Post Office (PO) Box addresses. A PO box does not define a physical residence.

FSD policies also require that "the case record...clearly shows...that all eligibility requirements...are met". However, FSD policies only require the caseworker to verify the applicant's address if it is "questionable"; there is no guidance as to when an applicant's statement might be considered questionable. Suitable documentation would include items such as a telephone or utility bill. In the absence of this type of documentation, the manual requires the caseworker to verify the address further. Possible verification could be provided by statements by relatives, school enrollment, etc. Verification of an applicant's address could be a primary defense against improper payments to ineligible persons since it is the only way FSD can be sure that applicants are Missouri residents.

Oversight recommends FSD reconsider its policy on address verification and documentation and require caseworkers to include address documentation in files for all applicants.

Family Composition

Oversight found three cases in which individuals listed on the application form were not included in the assistance group listed on the FSD computer system. We noted the following examples:

- The husband of a recipient was reported to have no income but that assertion was not verified with Department of Labor - Division of Employment Security (ES).

- Four individuals noted on one paper application form were not included in the FSD computer system or the assistance group.

- The current spouse of a married recipient was not included in the assistance group and his income was not considered in determining the family's eligibility.

Eligibility for most Medicaid programs depends on income and asset determinations for the family. Since we could not find the reason for excluding the individuals from the group and there was no financial information on these individuals, it was not possible to determine if eligibility records were correct for these recipient groups. Further, these were cases in which additional persons were actually listed on the application.

Oversight recommends FSD include financial information for all members of families unless there are legitimate, documented reasons for excluding the individuals.

Social Security Numbers

FSD requires caseworkers to obtain a copy of the Social Security card for all persons for whom coverage is requested at the time of the initial application, whenever possible. For family members of applicants who do not have a Social Security Number (SSN), proof of an application must be obtained prior to that individual's approval. If the number is known but a card is not available, the caseworker is instructed to accept the applicant's statement and verify the SSN in the FSD

computer system. If the number is correct, it will be verified by the system. FSD only requires further verification if the system match fails.

A. Verification of an applicant's SSN is required only for those persons for whom healthcare coverage or cash assistance is being requested or received. FSD does not apply this requirement to individuals such as parents, children, or a spouse included in the family, for whom assistance has not been requested. Since the SSN is the primary identification method used by the FSD system to obtain information from the Division of Employment Security and the Social Security Administration, and eligibility for many Medicaid programs is based on family income, verification of a SSN for all family members appears necessary.

B. FSD allows a caseworker to accept the applicant's statement of age unless it appears questionable, but requires further documentation if age is a critical factor of eligibility for a program and the applicant's statement is questionable. Verification of the Social Security number by the system is acceptable verification of age. FSD recognizes documents of almost any kind, such as birth certificate or drivers license, which state the age of the applicant at a given date as verification. As we have noted previously, we believe Social Security Number verification should be required for all individuals listed on the application to ensure that benefits are paid only to eligible persons.

Oversight recommends FSD require caseworkers to verify Social Security numbers and birthdates for all applicant family members.

Comment 2

Recipient income is not adequately verified.

APPLICANT INCOME VERIFICATION

An applicant's income is a principal eligibility measurement for nearly all components of the Medicaid program. Although many recipients are children, elderly or disabled adults, FSD requires caseworkers to verify family earned income for all Medicaid eligibility determinations and describes acceptable verification procedures according to the circumstances.

Pay Stub Review

FSD procedures allow caseworkers to accept a single pay stub, along with the applicant's statement of earnings, as verification of earned income so long as it does not "appear questionable". The procedure gives no guidance as to what might be considered questionable. If the applicant's statement of earnings "appears questionable", the caseworker is instructed to request additional pay stubs or a statement from the applicant's employer for more accurate information.

As we have noted previously, FSD has access to reported earnings and benefits from the Department of Labor - Division of Employment Security (ES). This data should be considered far more complete for past employment history. The process for obtaining this information is simple and quick, and we believe FSD's use of this data for all applicants would prevent benefit payments to ineligible individuals. This ES data should be used in conjunction with pay stubs to verify applicant and recipient income.

"Lock-In" Process

We noted an unusual procedure in a case file where an applicant's earned income was variable. In an email, a supervisor instructed the caseworker to look at the applicant's earnings for every month until the caseworker found a month where the applicant would be eligible. The supervisor said lock the applicant in at using this month's earnings.

The FSD manual states that income eligibility should be based on need by projection. Projection is defined as the best estimate of the income and circumstances that will

exist. This estimate is based on reasonable expectation and knowledge of the individual's current, past, or future circumstances. The manual further states to look at the past 30 days. If income fluctuates to the extent that a 30-day period does not accurately indicate projected income, choose a method that accurately indicates future income. An average income calculation could be done annually which could reduce benefits for ineligible persons. The practice of locking in at a low monthly income appears to distort an applicant's true annual income and does appear to be in compliance with the FSD manual.

Oversight recommends FSD review ES data for all applicants and recipients, and instruct caseworkers to follow the FSD manual when an applicant has variable income.

Comment 3

FSD does not have an adequate way of identifying recipients' assets.

APPLICANT ASSET ISSUES

According to the FSD Income Maintenance manual, caseworkers are required to verify applicant's identified resources (assets) for programs (such as nursing care) with an available resource limit. The manual defines resources as cash and securities, real property, the cash surrender value of life insurance and pre-need burial plans, and personal property, and notes that the type of verification required depends on the type of resource. We noted the following instances in the files which appeared to indicate that recipients' reported assets were minimized to make them eligible for benefits.

A. Cash and Securities

The manual requires the caseworker to identify applicant balances in savings and checking accounts and time deposits, for programs which have limits on applicant resources. The manual then describes procedures for "verifying" these balances, including obtaining copies of current bank statements or other papers from the applicant. Alternatively, the manual suggests that verification can be obtained from the institution with the applicant's written

permission. We believe these steps are unlikely to provide any valid information, since an applicant could have funds in other banks or institutions.

For programs which have applicant resource limits, Oversight suggests FSD develop a reliable means of identifying applicant resources. One reliable way would be to review income tax returns. For applicants who do not have income tax returns, alternate methods should be developed by FSD.

B. Life Insurance and Pre-need Burial Plans

The cash surrender value (CSV) of a life insurance policy is counted as a resource when someone applies for Medicaid. However, if ownership of the life insurance policy is assigned to someone else, the CSV is not counted as a resource. Caseworkers are instructed to obtain this information directly from the insurance company, and applicants are required to sign documents authorizing their insurance company to confirm the ownership and CSV of life insurance policies.

Amounts paid in toward pre-need funeral contracts also are not counted as resources when a family applies for Medicaid. Caseworkers are instructed to obtain a copy of documents for paid pre-need burial plans, record the amount paid on the contract and note the election of irrevocability.

Further, if a life insurance policy is owned by an applicant but irrevocably assigned to fund a pre-need burial contract, the CSV of that life insurance policy is not counted as a resource. The caseworker is instructed to obtain verification from the funeral home of the pre-need burial contract between the funeral home and the applicant, and the irrevocable assignment of the applicant's life insurance policy.

We noted three files, discussed below, in which applicants had used cash on hand to purchase pre-need funeral contracts and/or annuity contracts, and assigned existing life insurance policies so that

available resources would not exceed program limits. We also noted two files in which annuities were purchased in an effort to convert excess assets into income at a level which does not exceed program limits.

- We noted one case in which a recipient transferred ownership of a life insurance policy to her daughter. The cash surrender value of the policy was $2,773.

- In another case, a recipient used a savings account to purchase a $5,998 pre-need burial service plan and an annuity in the amount of $16,416 which pays her while she is alive. At her death the balance goes to her son.

- Another recipient sold her house and bought a $25,000 annuity from the proceeds which pays her while she is alive; on her death the balance goes to her daughter. This recipient paid $4,663 for husband's funeral, and set aside $6,443 in a pre-need burial plan for herself.

C. Real estate owned

We noted a case in which the recipient quitclaim deeded her property (a house) for $10 on March 31 and applied for benefits on June 26. The value of house was not in the file but notes in the file indicated the recipient transferred the home because she couldn't afford to maintain it and did not want to worry about it. Federal and state law exempt property transfers from disqualifying an applicant for benefits if the reason for the transfer was unrelated to the benefit qualification process. However, the explanation for this particular transfer and the transfer price appear questionable.

We believe the diversion of applicants' assets into prepaid burial plans, annuities, and similar instruments should be limited to reasonable amounts as determined by FSD. We also believe that applicants' real estate transfers should be

reviewed for reasonableness as compared to fair market value when considering their eligibility for services.

Oversight recommends:

A. FSD develop more reliable procedures for identifying applicant resources.

B. FSD develop limits on amounts allowed in pre-need burial plans, annuities, and insurance policy assignments.

C. FSD consider additional limits on real estate transfers.

Comment 4

FSD processes do not integrate EDP systems.

AUTOMATION AND ELIGIBILITY MANAGEMENT

In our review, we found areas where we believe the Department of Social Services could improve its operations through enhanced computer (EDP) applications. We believe improvements to EDP systems could reduce the time and effort involved in documenting recipient eligibility, while providing more accurate and timely information for making decisions.

Client eligibility for the Medicaid program is determined by the FSD, which administers the state's income maintenance programs. A significant number of participants eligible for Medicaid services are eligible for other programs such as Food Stamps. While the income or family composition requirements vary by program, most income maintenance programs are based on income and family size.

A. FSD procedures for applicant intake involve completely separate application processes for determining a family's Income Maintenance (IM) and Food Stamp (FS) eligibility. A family's applications for FS and IM can be processed at the same time, but there appears to be no coordination between the applications or their processing. We noted that certain FSD forms and reports include information on multiple programs, but the same form would be printed multiple times indicating approval for each program. We noted that even paper files for recipients are separated by program. This practice led to multiple copies of the same

applicant data in the file, which would not be necessary if FSD programs used consistent forms and integrated procedures for all programs.

B. The Department of Social Services maintains a set of computer systems to document eligibility and activity in income maintenance programs, and another set of systems for the Medicaid program. Eligibility information such as income and family status must be entered separately into each system. A coordinated or combined system would appear to offer significant savings in time and effort involved in determining and documenting eligibility, since information would only be entered once to update the computer system for all programs.

C. We have noted a number of cases in other parts of this report which indicate that caseworkers have obtained information which was not reflected in the FSD computer system. Although this may indicate inattention by caseworkers, it is more likely due to reliance on an outmoded paper-form-based system. Information is recorded on paper and computer records are updated later, and not as a part of the actual application process. Further, computer records are only updated if an FSD employee initiates that update.

Since payments and other benefits are based on the computer record, benefit accuracy could be reduced by its dependence on such a long sequence of steps. A more reliable process would include a computer-based application that could automatically update the computer database at completion. A paper record for review and signatures, if it is considered necessary, could be created by printing the computer-based application.

Recommendation

The Oversight Division recommends the Department of Social Services reorganize and update the EDP services supporting the Medicaid program. The following features

should be incorporated into the system:

A. An integrated application process using consistent and coordinated forms and reports for all programs.

B. Eligibility information such as family status and income maintained in a central record and available automatically from one program to all other programs.

C. Computerized applications which automatically update central eligibility records on completion and approval.

Comment 5

FSD is not completing annual reverifications on a timely basis.

REVERIFICATIONS

We noted in our review of recipient files that FSD annual eligibility reviews for 35 of 79 (44%) Medicaid files reviewed had not been completed on time. Reverification for 25 files were more than a year overdue. FSD has indicated understaffing as a primary factor in delinquent reverifications; however, we noted there may be significant savings in staff time available from procedure changes.

A. Recipients of Medicaid and Food stamps

We noted that a large number of Medicaid recipient files had no current information in their files. Some of these recipient files even indicated that an eligibility reinvestigation was required (but not completed) several years prior to our review. One file reviewed had not had a Medicaid budget run since 1995. Many of these Medicaid recipients were eligible for Food Stamps and the required semi-annual Food Stamp reinvestigation had been performed for most of these applicants. Eligibility criteria for the Food Stamp and Medicaid programs differ; however, income and family size is generally the determining factor for both programs.

We concluded that most of these recipients were eligible for Medicaid based on information in the Food Stamp reinvestigation. However, we believe that continued eligibility for Medicaid should be adequately documented on an annual basis as

required by FSD policy. At a minimum, wage verification, family size and composition, and a budget calculation should be documented in the Medicaid section of the case file.

B. Access to Reverification Information

We noted that FSD already has access to a significant amount of the required reverification data through its computer system. The system obtains SSN verification and benefit information from the Social Security Administration and reported earnings and Unemployment Benefit payments from the Department of Labor and Industrial Relations, Division of Employment Security. Information on other assistance programs administered by the state should be readily available also.

C. Automated Reverification Process

Current practice requires an FSD employee to initiate the review of each Medicaid recipient's continued eligibility by requesting data individually from the department's computer system. We believe that reverification could be initiated on a scheduled basis without the need for an employee to specifically request the information. FSD employees would have a start on the needed reverification information when they meet with the recipient for other reverification information.

In addition, information such as wages, federal benefits, and income maintenance payments could be reported automatically from the department's systems throughout the year and a report on recipients with status changes could be automatically provided to caseworkers for their attention. An edit report could be printed in cases where information is not available or appears incorrect, and staff effort could be directed to issues requiring their direct involvement.

D. Low Risk Recipients

We noted that many Medicaid recipients, especially the blind, the totally and permanently disabled, and the elderly, would likely remain eligible for extended periods of time. Put another way, there is very little risk that these individuals would receive inappropriate benefits because their situations are unlikely to change. Since continued eligibility for these recipients could likely be reverified through the automated records with little caseworker involvement, FSD could achieve significant savings in caseworker time as well as reduce its reverification backlog. Staff time saved could be redirected to case files for recipients more likely to having changing circumstances.

Oversight recommends FSD update Medicaid eligibility records from completed Food Stamp reverifications, develop a scheduled reverification program for all files, and develop an automated reverification system for low-risk recipients.

Comment 6

Medicaid recipients with access to other insurance are not adequately coordinated.

COORDINATION OF BENEFITS

In our review of case files, we noted there were concerns in coordinating benefits between the Medicaid program and other insurance coverage which recipients had or were eligible to receive. The Health Insurance Premium Payment (HIPP) program is a Medicaid component program that can evaluate the cost and coverage of other health care plans and, can pay for the cost of health insurance premiums, coinsurance requirements, and deductibles for recipients who have other coverage available. In many instances, it can be advantageous to enroll Medicaid participants in other health care plans. FSD policy requires all applicants and recipients to be evaluated for HIPP, and requires applicants and recipients to apply for HIPP if they are employed or lost employment within the past 30 days, and the employer offers group health insurance.

A. In our review of 125 recipient files, we noted three instances in which the recipient noted on the application that group health insurance was available. We forwarded these files to Division of Medical Services (DMS) management. DMS was

not able to provide additional information for any of these three files, and none had been referred to the HIPP unit as required.

B. We obtained a listing of state employees receiving public assistance and selected a sample from that list, since all full-time state employees are eligible for state employee health insurance through the Missouri Consolidated Health Care Program (MCHCP) or other state agency group health insurance programs. We selected a sample for detail review and of 44 files reviewed, we found 6 state employees enrolled in Medicaid, and 16 state employees had enrolled their dependents in Medicaid. None of these files had been reviewed by the HIPP unit as required because they had not been referred by a caseworker or not enough information was received by the HIPP unit.

State employees and their dependents may be eligible for Medicaid coverage provided they meet program requirements, and we noted these employees met the income and other guidelines for program participation. It appears these employees elected the Medicaid program instead of state sponsored group health insurance because of its lower cost to the employee and broader coverage. We believe significant savings could possibly be achieved by referring these cases to the HIPP for coordination of coverage.

FSD procedures for developing HIPP unit cases rely on the caseworker identifying other insurance coverage, recording it in the file, and initiating the referral to the HIPP unit. The FSD computer system does not provide or facilitate that process. An automated system could make the referral process a lot more reliable and could potentially result in significant savings.

Oversight recommends FSD develop procedures to improve the HIPP unit referral process, and to evaluate the potential benefit and cost of developing an automated system.

Comment 7

FSD continues benefits to recipients based on outdated information.

QUESTIONABLE RECIPIENTS

In our review of 125 case files, we noted the following examples which appeared to indicate that persons and/or families were receiving benefits as of August, 2004, based on old or incorrect information.

A. In one file information for the family had not been updated since the last benefit budget was prepared one year ago. Our review indicated that annual income had increased $2,400. This family was still receiving benefits based on the earlier budget.

B. There was no updated information in one file since 1996; the last benefit budget in 1995 showed no income. Our review indicated the recipient is earning $1,855 a month but still receiving benefits based on the earlier budget.

C. One current recipient file had no updated income information since 2001 although two children were added to the case file in 2003. The file indicated no income, but our review indicated family income was $1,459 per month. This family was still receiving benefits based on the earlier budget.

D. One file indicated the recipient was notified of the family's ineligible status due to excess income in 2002 but the recipient was still receiving benefits based on a previous budget.

E. Another file indicated the recipient was notified of benefit termination as of May 13, 2004 for failure to provide reinvestigation information; the last reinvestigation was in 2002. We noted the recipient was still receiving benefits based on a previous budget.

F. Another file had not been updated since the original application in 2001. Our review indicated monthly earnings of $2,422 a month; FSD notified the recipient that benefits would terminate on August 12, 2004.

Oversight did not recalculate benefit budgets or estimate overpaid benefits since additional investigation of the

families' circumstances such as family composition, family income, etc. would be required by contacting the individuals involved. This additional investigation falls within the caseworkers' duties. We note that these illustrations are consistent with procedural difficulties discussed throughout the report.

Oversight recommends FSD update all active recipient data as required to properly determine eligibility for benefits.

Comment 8

FSD is providing benefits to recipients with addresses in other states.

RECIPIENTS WITH ADDRESSES IN OTHER STATES

Address Verification

Because the Medicaid program is supported partly by state tax revenues, Oversight believes that only Missouri residents should be covered by the Missouri program. Accordingly, we asked FSD to prepare a listing of all active Medicaid recipients with addresses outside the state.

A. We received a list from FSD containing 274 persons, but we noted that 75 of those addresses contained Missouri city names and zip codes, but other states (for example, St. Louis, MI, Kansas City, MS, etc.) due to typographical errors.

B. A number of recipients claimed a Missouri residence but reported an out of state address. Some appear to reside on the state line, others hold a Post Office box in the other state, and still others requested that mail be forwarded to a relative residing outside Missouri. However, 12 of 27 (44%) files reviewed contained no reference to a verified residence in Missouri.

C. One recipient asked FSD to send all correspondence to an Arkansas address. When asked to provide a utility bill proving Missouri residence, the recipient claimed to be living without running water or electricity. No further investigation was made.

D. One letter to a recipient was returned to FSD on March 30, 2004, listing a forwarding address to Kansas. That case remained open until

September 27, 2004; it was closed after Oversight requested the file.

E. One recipient had a Kansas mailing address on the FSD system. We found no other information regarding this address and no verifications or re-certifications since February 2002. This case was closed on October 5, 2004, after Oversight requested the file.

F. We noted an email dated September 23, 2004, in one recipient file which asserted that "someone changed this client's address to her new address in Florida, but did not close the case." Coverage was terminated on October 20, 2004, after Oversight requested the file. There was no indication as to how long the recipient had received Missouri benefits while residing in Florida, who changed the address, or why.

G. One recipient had an Arkansas address; we noted a letter in the file from a taxpayer sent in 2002 which stated that the recipient lived in Arkansas. FSD did not investigate or take any action on this report, and the recipient continues to receive Missouri Medicaid benefits with an Arkansas address.

Oversight assumes that an out-of-state mailing address indicates out-of-state residence unless there is substantial evidence to suggest otherwise. We believe FSD should verify recipient's residency status on at least an annual basis, especially in cases where recipients have mail routed to an out of state location.

Employment and Income Verification

When recipients live near a bordering state, the possibility exists that they might be employed in that border state.

A. FSD verifies recipient income reported to the Missouri Division of Employment Security, but there is currently no system of verification for income from other states. We noted that 18 out of 27 (67%) of the files we reviewed had recipient mailing addresses in other states but no verification of potential employment or government benefits

received in that other state.

B. Oversight reviewed its 125 sample items for employment in states bordering Missouri. We found five files including seven individuals where individuals' Social Security Numbers matched border state employment records. Each file was then reviewed to determine whether: (a) FSD had performed the required annual reverification, (b) the recipient had notified FSD of changes in family income, and (c) FSD had included income from appropriate family members in determining eligibility.

   In one case out of the five we found that both the recipient and her husband were employed. There was no indication in the file that the recipient had notified FSD of a family member's Kansas employment or of her own employment status. FSD policies require recipients to notify FSD within 10 days of any changes in circumstances. In this case, the combined income for the recipient and spouse would have made them ineligible for benefits.

We noted that FSD cancelled a multi-state reporting service in April, 2003. The FSD cancellation memo stated that the service could not be cost-justified but cost information was not provided, and FSD did not replace that service.

Based on our review, it appears such a service could be justified if FSD had a way to determine when to use such a service, and a way to apply information from such a service. We do not believe FSD has the capability to do so with existing systems, and we believe FSD should evaluate the expected benefits and cost of developing such a system before proceeding.

<u>Oversight recommends:</u>

A. A periodic verification of address and residency for all recipients, especially those with an out of state address.

B. FSD evaluate the expected benefits and cost of developing a system to verify recipients' income and benefits in other states, and implement such a system if warranted.

Comment 9

FSD has not adequately coordinated Medicaid coverage for state employees

State Employees on Medicaid

Oversight requested a comparison of active state employees on Medicaid with state payroll data for health care premiums. We found 325 employees who had Medicaid and state employee health care plan coverage. When we discussed the status of these employees with FSD management, they told us it was possible for a state employee to be active in both systems, and gave us examples:

A. New state employee who was previously unemployed or employed but without health care benefits. There might be some overlap of coverage during a job transition.

B. Terminated state employee who is currently unemployed or employed but without health care benefits. There might be some overlap of coverage during a job transition.

C. State employee on leave without pay. There might be some transition circumstances in which both types of coverage would be available.

D. State employee in Health Insurance Premium Payment (HIPP) program. Some state employees might have unusual personal circumstances in which Medicaid funds would be used to pay state health care plan premiums and deductibles.

E. State employees with a condition such as blindness that creates automatic Medicaid eligibility.

F. State employee who is Medicaid qualified due to income and family size and elects Medicaid coverage due to the broader coverage and lower employee cost as compared to the state employee health care plan.

We have requested a FSD review of the individual

circumstances of the 325 employees, including actual dates enrolled in Medicaid programs and Medicaid expenditures for the employees. At this time, we have not received that analysis.

The cost of participating in the Missouri Consolidated Health Care Plan, the state plan for most state employees, is $471 per employee per month. It appears that the State of Missouri is paying $1,836,900 ($471 x 325 employees x 12 months) in duplicate costs for employer sponsored health insurance when the state is also providing Medicaid coverage for these same people.

Oversight recommends FSD review Medicaid eligibility standards for active state employees and develop procedures to ensure that the most cost-effective combination of state employee healthcare plan and Medicaid coverage is provided. The procedures should eliminate duplicate coverage unless it is advantageous to the state.

APPENDIX

INCOME GUIDELINES
FOR MC+, MAF AND TEMPORARY ASSISTANCE

NUMBER OF PERSONS	TEMPORARY ASSISTANCE			MEDICAL ASSISTANCE FOR FAMILIES	NON-CHIP MC+ AGES 6-18	NON-CHIP MC+ AGES 1-5	NON-CHIP MC+ UNDER AGE 1 & MC+ FOR PREGNANT WOMEN	MC+ CHIP GROUPS (UNINSURED CHILDREN) THROUGH AGE 18			GAFP
		Eligibility Test	Net Income Limit/Maximum	NET INCOME MAX	NET INCOME MAX	NET INCOME MAX	NET INCOME MAX	GROSS INCOME MAX FEDERAL POVERTY			GROSS MAX
	Gross Max	Cons. Std.	Grant Amt	75% of Federal Poverty Level	100% of Federal Poverty Level	133% of Federal Poverty Level	185% of Federal Poverty Level	NO-COST 185%	CO-PAY 225%	PREM 300%	FPL FPL
1	727	393	136	582	776	1032	1436	1436	1746	2328	1552
2	1254	678	234	781	1041	1385	1926	1926	2342	3123	2082
3	1565	846	292	980	1306	1737	2416	2416	2939	3918	2612
4	1832	990	342	1179	1571	2090	2907	2907	3535	4713	3142
5	2078	1123	388	1377	1836	2442	3397	3397	4131	5508	3672
6	2307	1247	431	1576	2101	2795	3887	3887	4727	6303	4202
7	2538	1372	474	1775	2366	3147	4377	4377	5324	7098	4732
8	2755	1489	514	1974	2631	3500	4868	4868	5920	7893	5262
9	2971	1606	554	2172	2896	3852	5358	5358	6516	8688	5792
10	3186	1722	595	2371	3161	4204	5848	5848	7112	9483	6322
11	3402	1839	635	2570	3426	4557	6338	6338	7709	10278	6852
12	3619	1956	675	2769	3691	4909	6829	6829	8305	11073	7382

Temporary Assistance:

If under gross income limit, deduct child care expenses and $90 work standard and compare to consolidated standard.
If under the consolidated standard, income after allowable deductions, must be under the net income limit to be eligible.

Medical assistance for Families, MC+ for Pregnant Women, and Non-CHIP Children:

Deduct child care expenses and $90 for each wage earner from gross income - compare to poverty level.

CHIPS groups:

Gross income must be under maximum. There are no deductions.

Transitional Medical Assistance eligibility (for the second six-month period of eligibility) is determined by subtracting childcare expenses from earned income and comparing the result to 185% of the current federal poverty level.

GAFP - Grandparents as Foster Parents

MEDICAID EXPENDITURES BY LARGE ELIGIBILITY GROUPS

FISCAL YEAR 2003

Expenditures (In Millions)	[1] Elderly	Transitional Assistance for Needy Families - Adult	Transitional Assistance for Needy Families-Child	[2] Disabled	Foster Care	[3] Children in State Custody	[4] Pregnant Women	Medicaid for Children	MC+ for Kids (State Children's Health Ins Program)	Uninsured Parents	General Relief (Temporarily Disabled)	[5] All Other	Total
	Title XIX	Title XIX	Title XIX	Title XIX	Title XIX	Title XIX	Title XIX	Title XIX	Title XXI	1115 Waiver			
Fed/state match rate	61 / 39	61 / 39	61 / 39	61 / 39	61 / 39	61 / 39	61 / 39	61 / 39	73 / 27	61 / 39	0 / 100	**	
Nursing Facilities	$592.9	$0.2	$0.1	$125.9	$0.0	$0.1	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$719.2
Hospitals	$53.9	$83.0	$87.4	$405.9	$7.7	$14.9	$33.8	$52.6	$14.4	$1.1	$3.2	$1.1	$759.0
Dental	$2.5	$5.9	$2.6	$8.0	$0.1	$0.1	$0.1	$0.6	$0.8	$0.0	$0.0	$0.4	$21.1
Pharmacy	$248.1	$55.9	$41.5	$537.7	$5.2	$7.5	$3.1	$14.0	$12.5	$1.2	$5.4	$0.5	$932.6
Physician	$34.2	$40.9	$23.9	$109.2	$1.4	$2.1	$16.6	$9.4	$5.7	$0.9	$3.0	$0.3	$247.6
In-Home	$163.5	$1.1	$0.1	$143.8	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.1	$0.0	$308.6
Rehab & Spec	$43.5	$4.6	$5.8	$69.6	$0.4	$0.9	$0.5	$1.8	$1.3	$0.1	$0.6	$0.1	$129.2
Buy-In	$33.7	$0.4	$0.0	$31.9	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$5.1	$0.0	$71.1
Mental Health	$14.0	$8.0	$11.0	$298.5	$1.9	$8.0	$0.6	$5.5	$3.0	$0.0	$0.0	$1.4	$351.9
State Institutions	$6.3	$0.2	$5.2	$127.5	$34.1	$49.6	$0.0	$2.9	$1.7	$0.0	$0.0	$2.5	$230.0
EPSDT	$0.1	$1.0	$49.5	$19.9	$12.9	$17.5	$1.0	$17.7	$11.5	$0.0	$0.0	$2.5	$133.6
Managed Care	$0.0	$189.4	$286.4	$0.0	$11.9	$9.8	$14.1	$95.9	$46.0	$1.4	$0.0	$1.5	$656.4
Total (in millions)	$1,192.7	$390.6	$513.5	$1,877.9	$75.6	$110.5	$69.8	$200.4	$96.9	$4.7	$17.4	$10.3	$4,860.3

	[1] Elderly	Transitional Assistance for Needy Families - Adult	Transitional Assistance for Needy Families-Child	[2] Disabled	Foster Care	[3] Children in State Custody	[4] Pregnant Women	Medicaid for Children	MC+ for Kids (SCHIP)	Uninsured Parents	General Relief (Temporarily Disabled)	[5] All Other	Total
Number of Enrollees	80,404	164,790	328,336	133,070	12,119	10,973	15,917	86,262	80,435	11,315	2,936	1,467	[illegible]
Annual Cost Per Person	$14,728	$2,370	$1,564	$14,112	$6,236	$10,072	$4,406	$2,323	$1,204	$411	$5,915	$6,971	$5,859
Monthly Cost Per Person	$1,227	$198	$130	$1,176	$520	$839	$367	$194	$100	$34	$493	$581	$488
Monthly State Cost Per Person	$479	$77	$51	$459	$203	$327	$143	$75	$27	$13	$493	*	

(Source: Table 5 for FY03)

*State Monthly Cost per Person and Federal/State match rate very by category of eligibility.

[1] Elderly includes the following categories: Old Age Assistance, Qualified Medicare Beneficiary

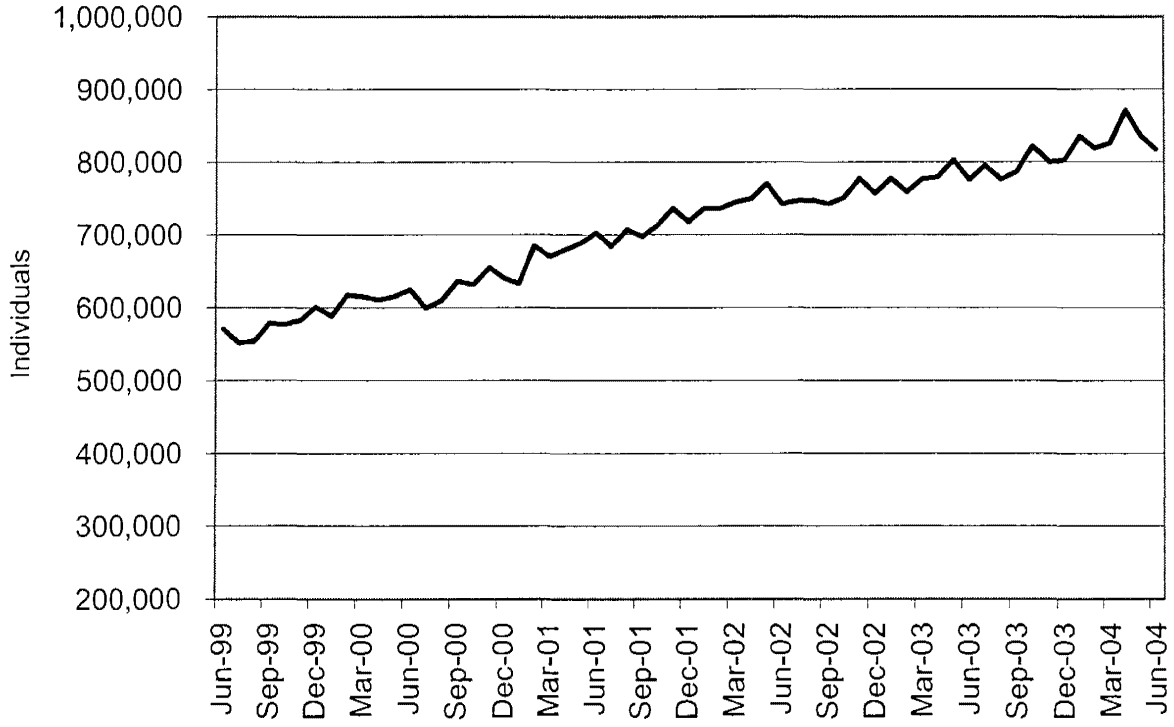
[2] Disabled includes the following categories: Blind Pension, Aid to Blind, Permanently & Totally Disabled, MAWD Premium, MAWD Non-Premium

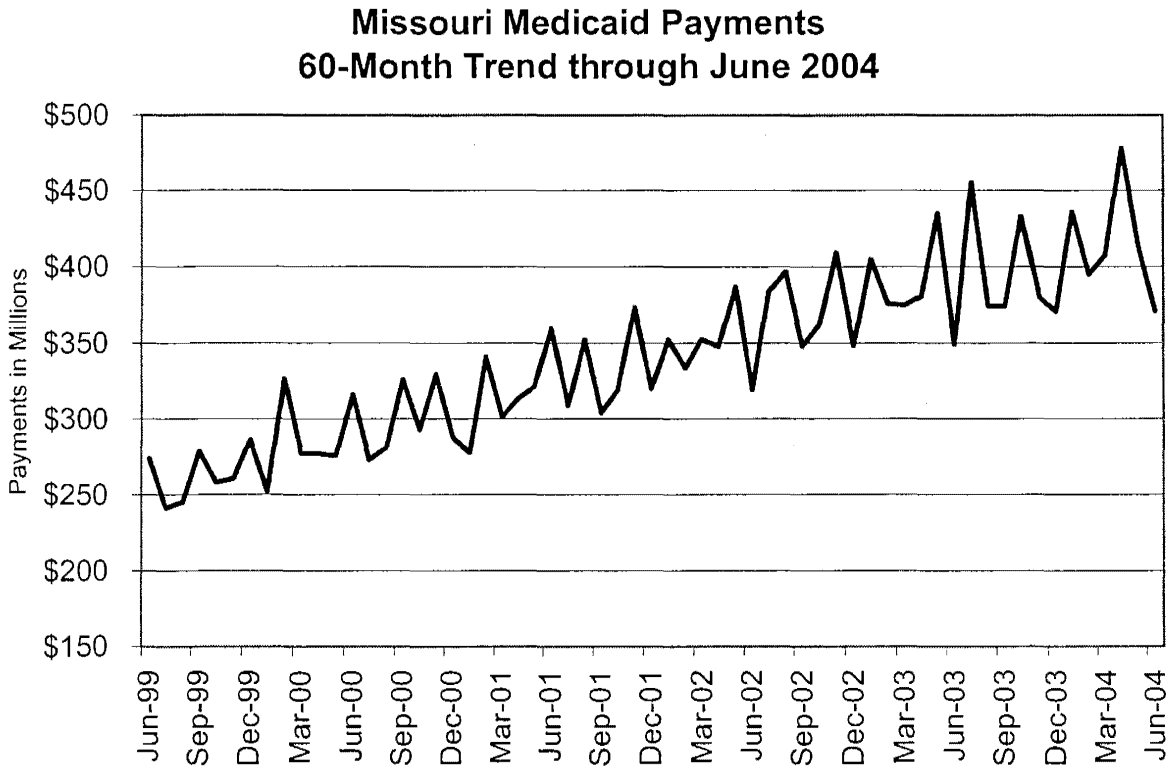
[3] Children in State Custody includes the following categories: MAF Children in Vendor Institution, Title XIX - HDN

[4] Pregnant Women includes the following categories: Medicaid for Pregnant Woman (MAF Income Limit), Medicaid for Pregnant Woman (Poverty)

[5] All Other includes the following categories: Child Welfare Services, Refugee, DYS General Revenue, MOCDD

Missouri Medicaid Recipients
60-Month Trend through June 2004




Missouri Medicaid Payments
60-Month Trend through June 2004
Payments in Millions
$500
$450
$400
$350
$300
$250
$200
$150
Jun-99
Sep-99
Dec-99
Mar-00
Jun-00
Sep-00
Dec-00
Mar-01
Jun-01
Sep-01
Dec-01
Mar-02
Jun-02
Sep-02
Dec-02
Mar-03
Jun-03
Sep-03
Dec-03
Mar-04
Jun-04

No. of People Eligible for Medicaid/MC+ FY03

County	# Eligible	Total Est. Pop. Jul 03	Percent of Pop. Eligibile	Per Capita Mediciad Dollars Spent	
Saline	4,591	22,887	20.0594%	$2,098	(Marshal Hab. Center)
Reynolds	2,123	6,581	32.2595%	$2,018	
Vernon	4,721	20,283	23.2756%	$1,974	
Dunklin	12,811	32,654	39.2326%	$1,751	
Pemiscot	8,529	19,729	43.2308%	$1,693	
Ripley	5,075	13,781	36.8261%	$1,665	
New Madrid	6,367	19,187	33.1839%	$1,655	
Mississippi	4,656	14,386	32.3648%	$1,565	
Iron	2,856	10,306	27.7120%	$1,500	
Butler	10,879	40,854	26.6290%	$1,482	
Wayne	4,382	13,090	33.4759%	$1,434	
Carter	2,043	5,974	34.1982%	$1,379	
St. Louis City	113,251	332,223	34.0888%	$1,324	
Scott	10,397	40,779	25.4960%	$1,310	
Atchison	1,074	6,286	17.0856%	$1,293	
Washington	6,567	23,884	27.4954%	$1,254	
Madison	2,658	11,804	22.5178%	$1,243	
Stoddard	6,778	29,626	22.8786%	$1,196	
Marion	5,798	28,289	20.4956%	$1,193	
Oregon	2,947	10,301	28.6089%	$1,189	
Dent	3,860	14,921	25.8696%	$1,134	
Shannon	2,746	8,293	33.1123%	$1,127	
Gentry	1,032	6,566	15.7173%	$1,122	
Lafayette	5,032	32,951	15.2712%	$1,094	
Sullivan	1,445	7,080	20.4096%	$1,086	
Cedar	3,337	13,838	24.1148%	$1,075	
Adair	3,924	24,790	15.8290%	$1,056	
Wright	5,251	18,186	28.8739%	$1,050	
Randolph	5,298	25,045	21.1539%	$1,033	
Harrison	1,741	8,828	19.7213%	$1,023	
Polk	5,958	28,081	21.2172%	$1,020	
Howell	9,638	37,499	25.7020%	$1,017	
St. Francois	12,111	57,929	20.9066%	$1,014	
Grundy	2,073	10,311	20.1047%	$1,012	
Bollinger	2,737	12,318	22.2195%	$1,008	
Hickory	2,159	9,005	23.9756%	$984	
Crawford	4,932	23,513	20.9756%	$975	
Montgomery	2,121	12,068	17.5754%	$961	
Henry	4,619	22,419	20.6031%	$947	
Macon	2,749	15,577	17.6478%	$937	
Jasper	23,919	108,112	22.1243%	$916	
Texas	5,585	24,142	23.1340%	$914	
Carroll	2,079	10,149	20.4848%	$912	
Phelps	8,225	41,668	19.7394%	$906	
Bates	3,067	16,937	18.1083%	$886	
Benton	3,920	18,076	21.6862%	$882	
Livingston	2,652	14,387	18.4333%	$867	
Ozark	2,569	9,498	27.0478%	$858	
Scotland	819	4,905	16.6972%	$855	
Dade	1,553	7,845	19.7960%	$849	
Pike	3,516	18,519	18.9859%	$847	
Morgan	4,160	20,000	20.8000%	$845	
Pettis	7,328	39,344	18.6255%	$845	
Linn	2,503	13,460	18.5958%	$843	
Douglas	3,507	13,363	26.2441%	$837	
St. Clair	2,083	9,679	21.5208%	$835	
Chariton	1,167	8,251	14.1437%	$833	

No. of People Eligible for Medicaid/MC+ FY03

County	# Eligible	Total Est. Pop. Jul 03	Percent of Pop. Eligibile	Per Capita Mediciad Dollars Spent
Schuyler	845	4,209	20.0760%	$819
Dallas	3,592	16,113	22.2926%	$816
Buchanan	14,909	84,909	17.5588%	$811
Barry	6,931	34,629	20.0150%	$797
Lawrence	7,043	36,426	19.3351%	$791
Shelby	1,234	6,702	18.4124%	$780
Putnam	1,114	5,148	21.6395%	$779
Miller	5,081	24,255	20.9483%	$777
Barton	2,625	12,999	20.1939%	$766
Laclede	7,738	33,326	23.2191%	$763
Howard	1,672	10,007	16.7083%	$761
Worth	397	2,270	17.4890%	$755
Perry	2,755	18,225	15.1166%	$754
Maries	1,494	8,841	16.8985%	$753
Knox	759	4,311	17.6061%	$747
Holt	816	5,145	15.8601%	$739
Monroe	1,493	9,396	15.8897%	$738
Gasconade	2,009	15,542	12.9263%	$726
McDonald	5,514	21,973	25.0944%	$716
Cape Girardeau	11,891	69,876	17.0173%	$708
Audrain	4,131	25,716	16.0639%	$706
Cooper	2,354	17,009	13.8397%	$688
Jackson	117,941	659,723	17.8774%	$688
Newton	8,830	54,033	16.3419%	$676
Lewis	1,591	10,226	15.5584%	$666
Caldewll	1,703	9,159	18.5937%	$662
Greene	37,883	245,765	15.4143%	$660
Dekalb	1,449	13,063	11.0924%	$656
Ralls	1,309	9,653	13.5606%	$655
Taney	7,588	41,403	18.3272%	$651
Callaway	6,266	42,225	14.8396%	$648
Clark	1,351	7,420	18.2075%	$644
Webster	5,853	33,124	17.6700%	$642
Ste. Genevieve	2,308	18,094	12.7556%	$629
Lincoln	6,689	44,207	15.1311%	$616
Mercer	550	3,596	15.2948%	$613
Boone	18,730	141,122	13.2722%	$587
Camden	6,157	38,302	16.0749%	$581
Daviess	1,469	8,004	18.3533%	$569
Pulaski	6,124	45,254	13.5325%	$550
Andrew	1,803	16,813	10.7238%	$548
Clinton	2,136	20,140	10.6058%	$546
Stone	5,773	29,941	19.2813%	$541
Franklin	11,466	96,905	11.8322%	$519
Christian	8,034	61,571	13.0484%	$515
Johnson	5,615	50,262	11.1715%	$508
Warren	3,213	26,862	11.9611%	$506
Ray	2,744	23,926	11.4687%	$495
Cole	8,144	72,454	11.2402%	$493
Osage	1,383	13,134	10.5299%	$490
Jefferson	23,297	206,786	11.2662%	$487
Moniteau	1,783	14,965	11.9145%	$486
Cass	8,874	88,834	9.9894%	$476
St. Louis Co.	105,031	1,013,123	10.3671%	$455
Nodaway	1,715	21,743	7.8876%	$453
Clay	16,080	194,247	8.2781%	$372
Platt	4,696	79,390	5.9151%	$321
St. Charles	18,703	311,531	6.0036%	$292

Response to Legislative Oversight Review of Medicaid Eligibility

Overall Comment:

In this review, Oversight takes exception to some Family Support Division policies and practices related to determining Medicaid eligibility. Our current policy *does* require verification of all eligibility criteria, in compliance with current federal and state laws. There is some discrepancy about what constitutes "adequate" documentation or verification. Our current policies regarding what is adequate have been developed from federal guidance, case law, and program experience with cost-effective use of scarce resources.

Comment 1: FSD did not adequately document that recipients met all eligibility requirements.

Recommendation: FSD require birth records for verification of age and relationship of a child to their parent or caretaker in all cases.

Response: Current policy is to verify age and relationship of a child to their parent/caretaker by checking birth records for children born in Missouri that is available to FSD through an interface with the Department of Health and Senior Services. For children born outside Missouri, the policy is to accept the applicant's statement, unless questionable. FSD feels this is an appropriate policy as age is verified when the Social Security Number is verified through a match with the Social Security Administration. Relationship of the parent/caretaker to child only affects how much income is counted to determine the child's eligibility. If a child's caretaker is someone other than a parent, the caretaker's income is not counted based on Section 1902(a)(17)(D) of the Social Security Act and federal regulation 42 CFR 435.602. If the person whose statement we accept is not the parent, it would result in counting less income. If Medicaid coverage is requested for the caretaker, that person does have to be a parent, specified relative or legal guardian. The review found no examples of cases in which benefits were provided to a caretaker who was not a parent, specified relative or legal guardian.

Recommendation: FSD require address documentation in be included in the files for all applicants.

Response: The eligibility factor is residence in the state of Missouri, not at a specific address. Current policy is to accept the client's statement unless questionable. In the comments on addresses, the report notes that the policy does not provide guidance on when the applicant's statement should be considered questionable. FSD will review adding this guidance, along with what verification should be obtained to establish Missouri residence when it is questionable.

Recommendation: FSD include financial information for all members of families unless there are legitimate, documented reasons for excluding the individuals.

Response: Current policy is to include financial information for all family members in the home whose income and resources are required to be counted in determining Medicaid eligibility. Section 1902(a)(17)(D) of the Social Security Act and federal regulation 42 CFR 435.602 prohibit the state from considering income and resources of

persons other than the Medicaid applicant/recipient's spouse and parents of persons receiving as a child.

Recommendation: FSD require verification of Social Security numbers and birthdates for applicant family members.

Response: Current policy does require all persons applying for Medicaid to divulge their Social Security number and age. The Social Security number is then sent to the Social Security Administration for verification. This is in compliance with Sections 1137 and 1902(a) of the Social Security Act and federal regulations 42 CFR 435.910 and 42 CFR 435.920. On Oct. 31, 2004 only 19,944 (2.1%) of Medicaid recipients did not have a Social Security Number entered in the Income Maintenance system. 18,968 are children under age 19, of which 40.3% are under age 1 and 86.8% are under age 6.

Under these federal guidelines, the state cannot require a family member who is not requesting Medicaid coverage for him- or herself to supply their Social Security number. However, in almost all cases FSD has received the Social Security number of the parents and spouses of Medicaid recipients. On Oct. 31, 2004 there were 161,090 parents not receiving Medicaid on cases where their children were receiving. The Social Security number was in the Income Maintenance system on all but 7,494 (4.7%) of these parents. There were 10,553 spouses not receiving Medicaid on cases their elderly or disabled spouse was receiving. Only 113 (1.1%) of these did not have a Social Security number in the system.

Comment 2: Recipient Income is not verified.

Response: Current policy requires all recipient income be verified.

Recommendation: FSD review Employment Security data for all applicants, and instruct caseworkers to follow the FSD manual when an applicant has variable income.

Response: This is current policy. FSD will add explicit instructions to the policy manual that review of Employment Security data is required at each application and annual reinvestigation.

Comment 3: FSD does not have an adequate way of identifying recipients' assets.

Recommendation: FSD develop more reliable procedures for identifying applicant resources.

Response: From discussion with Oversight, we believe this concern is with identifying resources applicants do *not* claim. While we verify all resources claimed, we have some methods to discover resources that are *not* claimed. Among these are our annual IRS match, which identifies income-producing resources that recipients may or may not have claimed. We are open to other suggestions on how to identify resources not claimed by applicants.

Recommendation: FSD develop limits on the amounts allowed in pre-need burial plans, annuities and insurance policy assignments.

Response: FSD has policy on these types of assets, which are treated, either as available, unavailable or a transfer of assets. These policies are based on federal and state laws and federal guidance. The state is only allowed to impose penalties for transfers of assets on persons applying for Medicaid coverage of nursing facility and waiver (to prevent the need of placement in a nursing facility) services. This is required by Section 1917 of the Social Security Act.

Recommendation: FSD consider additional limits on real estate transfers.

Response: Section 1917 of the Social Security Act does not allow a change in current policy. Section 208.010.8 RSMo. directs us to follow the federal law regarding transfer of assets.

Comment 4: FSD processes do not integrate EDP systems.

Response: Eventually all eligibility for all FSD programs will be in an integrated system (FAMIS). Currently Food Stamp and Child Care determinations are in the FAMIS system, Medicaid is in the legacy system. FSD began piloting Temporary Assistance determinations in FAMIS on November 15, 2004. Temporary Assistance will be completely in FAMIS by June 2005. ISTD is currently working on changes to the legacy system that will allow FAMIS information to update Medicaid cases prior to Medicaid moving to FAMIS.

Comment 5: FSD is not completing annual reverifications on a timely basis.

Recommendation: FSD update Medicaid eligibility records from completed Food Stamp reverifications, develop a scheduled reverification program for all files, and develop an automated reverification system for low-risk recipients.

Response: Current policy allows caseworkers to complete the annual Medicaid reinvestigation based on information from a Food Stamp approval or recertification. FSD is working with ISTD to make this an automated process; this project should be completed by early spring. FSD agrees that if staffing levels do allow for timely completion of all reinvestigations, priority should be given to those most at risk of having a change. FSD does an automated update of all Medicaid files based on the annual increase in the amount of Social Security and Supplemental Security Income (SSI) benefits.

Comment 6: Medicaid recipients with access to other insurance are not adequately coordinated.

Recommendation: FSD develop procedures to improve the HIPP unit referral process, and to evaluate the potential benefit and cost of developing an automated system.

Response: FSD will explore ways to do this with the Division of Medical Services.

Comment 7: FSD continues benefits to recipients based on outdated information.

Response: See response to comment 5.

Recommendation: FSD update all active recipient data as required to properly determine eligibility for benefits.

Response: See response to Comment 5.

Comment 8: FSD is providing benefits to recipients with addresses in other states.

Recommendation: A periodic verification of address and residency for all recipients, especially those with an out-of-state address.

Response: Current policy is to accept the client's statement of residence unless questionable. Refer to the response to the second recommendation under Comment 1. FSD agrees that an out-of-state address is a reason to question residence in Missouri.

Recommendation: FSD evaluate the expected benefits and cost developing a system to verify recipients' income and benefits in other states, and implement such a system if warranted.

Response: FSD currently participates in the federal PARIS match which provides information on persons receiving benefits in multiple states, and is looking in to ways to better utilize the information. We will explore ways and the costs of getting income information from other states. (We previously had a multi-state information exchange.

In the past two to three years, the other states dropped out due to budget constraints and cost-effectiveness.)

Comment 9: FSD has not adequately coordinated Medicaid coverage for state employees.

Recommendation: FSD review Medicaid eligibility standards for active state employees and develop procedures to ensure that the most cost-effective combination of state employee healthcare plan and Medicaid coverage is provided. The procedures should eliminate duplicate coverage unless it is advantageous to the state.

Response: We believe from discussion with Oversight staff that this recommendation would be more appropriately directed to the Office of Administration. As we understand the recommendation, it is for the state to stop paying for employee health insurance for these state employees who are also Medicaid recipients.